# The right to die as an ethical dilemma for new physicians in Hawaii

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*In the Cruzan case, the U.S. Supreme Court acknowledged the patient's right to refuse treatment but limited the decision-making involvement of the family when the patient's wishes are unknown. A study of 118 graduating physicians at the John A. Burns School of Medicine revealed their most significant clinical experience involving an ethical dilemma during their 3rd and 4th years was their involvement with families in the decision to discontinue treatment for terminal patients. These findings underscore the need for a focus on this issue in the curriculum.*

## Introduction

Advances in medicine have outdistanced the development of guidelines for dealing with them and have produced a new set of ethical dilemmas for physicians. These dilemmas have been discussed in journals and medical school curricula, but empirical data about them is just beginning to be found in the scientific literature[1,2,3].

On June 15, 1990, in the case of Nancy Cruzan[4,5], the U.S. Supreme Court ruled on the first right to die case to come before it. In its ruling, the court assigned constitutional status to the right to die, ie it held that a competent patient has a constitutional "liberty" to refuse treatment, including tube-feeding. However, in the case of an incompetent patient, it required "clear and convincing evidence" of that wish to discontinue, limiting family involvement to cases in which the patient had specifically designated family members as surrogates. In the Cruzan case, the Court affirmed the right to die as a constitutional right and the role of the family as an extension of the patient's decision-making process. The Cruzan case, which was considered during the 1980s and was decided in 1990, confirmed the need for society to focus on the right to die as an important contemporary issue needing explicit guidelines. Our study, however, considered this issue prior to the Supreme Court's ultimate decision. The issue was chosen by our survey cohort as its most serious ethical dilemma faced during the clinical years of medical school.

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Received for publication on April 23, 1991.

## Method

As part of a required seminar in Medical Ethics, 2 weeks prior to graduation all 118 senior students in the classes of 1986 and 1987 anonymously submitted a description of the single most important ethical dilemma with which they had been involved during their medical education. The survey instructions read: "All people who think and feel have had experience with being in a situation where they had to make a decision, but weren't sure what was the right thing to do. Think of a time during your clinical experience when you faced an ethical dilemma, ie when you had to decide between two alternatives both of which were important. (A) Describe such a situation and clearly articulate the conflict for you in that situation. (B) In thinking about what to do, what did you consider and why did you consider it? (C) What did you decide to do? What happened? (D) Do you think it was the right thing to do? Why? Why not? (E) When you think back over the conflict, do you think you learned anything from it?" The responses were analyzed and grouped by major dilemmas.

## Results

Of the 118 ethical dilemmas reported (see Table 1), the largest number (43) dealt with the patient's right to die when the prognosis was hopeless. In 7 of these cases, the decision to discontinue treatment was made by the patient and the attending physician alone. In the majority (36 cases), however, the families were involved in the decisions. In view of the Cruzan decision, these 36 cases will be considered in some detail (see Table 2).

## Discussion

In half of the cases in which the patient had a Living Will or had clearly expressed the wish to be allowed to die and to discontinue further treatment and/or life support, the family supported the patient's wish, while in the other half they opposed it or were split. In these instances, the physician, assisted by the student, mediated in order to reach resolution in favor of the patient's own wish to be allowed to die.

Example: The condition of a 54-year-old man with a mas-

TABLE 1
Medical Student Dilemmas (N = 118)

| | |
|---|---|
| Right to Die | 43 |
| Informed Consent | 24 |
| Confidentiality | 18 |
| $D_X$ and $R_X$ Decisions | 11 |
| Personal Values | 11 |
| Laboratory Tests | 7 |
| Other (public health issues) | 5 |
| | 118 |

sive myocardial infarction was deteriorating. The attending physician wished to change the code status and stop heroic measures. The wife and son were in agreement with the patient's expressed wish to die with dignity. However, the patient's daughter disagreed and wanted treatment continued. The physician worked out a compromise in which heroic measures were to be continued for 24 hours and then discontinued.

In the majority of cases the comatose patient had no Living Will and his/her wish was not known. In most of these cases, the family's decision was to allow the patient to die peacefully, in several instances after significant physician involvement in educating the family about prognosis, options and cost were carried out. In other instances, the family requested that "everything possible be done" and that the patient be kept alive, even though terminal. This decision was respected. In a similar number of cases, however, the family requested that treatment be discontinued *against* the attending physician's judgment.

In summary, 2 major findings stand out. First of all, student physicians are frequently involved in cases of terminally ill, incompetent patients who do not have a Living Will and the dilemma of how far to go in sustaining life when the prognosis is hopeless has to be addressed. Second, in a significant number of cases, the family's wishes present the student physician with an ethical conflict. Indeed, it appears that the most common ethical dilemma for student physicians in the clinical years is the difference between the wishes of the patient and his or her family whether to discontinue treatment. Thus, there appears to be a spectrum of decision making with varying degrees of physician involvement along the line.

**Conclusion**

It is estimated that 7 out of 10 Americans will some day directly confront questions of life-sustaining medical care for themselves or for relatives. Society supports the right of the individual patient to discontinue treatment. However, when that wish is ambiguous, family involvement complicates the doctor-patient relationship and requires active assessment and compassionate management by the physician. Most often a resolution of conflict between patient and family occurs through education and counseling by the physician regarding prognosis, outcome, pain and suffering. Thus, the physician must become a diagnostician of the family's own needs and interests and integrate them into the care of the patient. The new Problem-Based Curriculum at the University of Hawaii's John A Burns School of Medicine emphasizes a special focus on training physicians to be involved with patients and their families when it comes to a question of dying.

TABLE 2
Right to Die (N = 43)

| | |
|---|---|
| Doctor-patient decision | 7 |
| Doctor-patient-family decision | 36 |
| Family agrees with patient's wishes | 9 |
| Family disagrees with patient's wishes | 10 |
| Patient's wish unknown | 17 |

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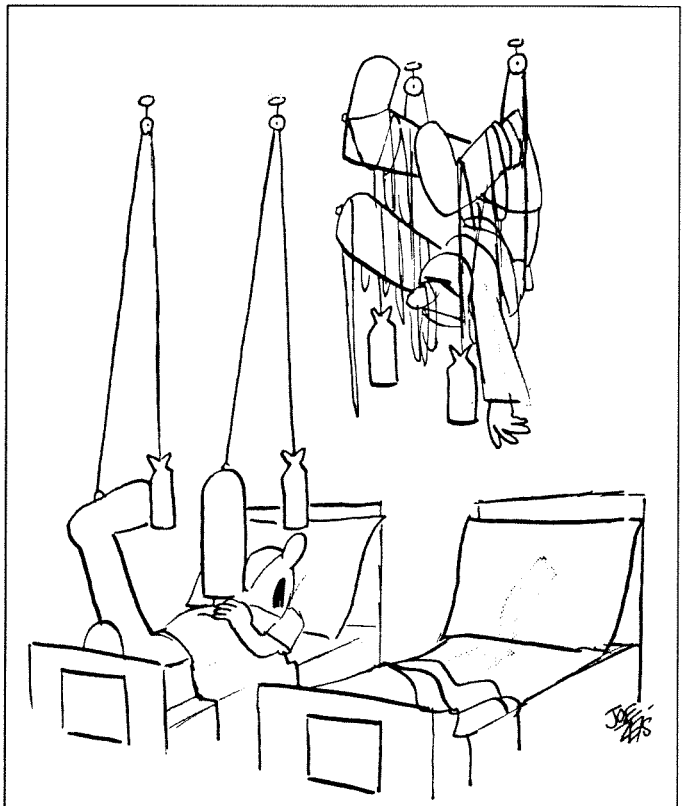

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